MAXIMUS Federal Services

Case Number:	CM15-0126137		
Date Assigned:	07/10/2015	Date of Injury:	06/01/2007
Decision Date:	09/18/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/30/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Anesthesiology

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 43 year old male who sustained an industrial injury on 6/1/07. The injured worker was diagnosed as having post-laminectomy syndrome, failed back syndrome - lumbar, coccygodynia, fibromyalgia/myositis, depressive disorder not elsewhere classified, and lumbar spine radiculopathy. Currently, the injured worker was with complaints of low back pain with radiation to the left lower extremity. Previous treatments included acupuncture treatment, status post spinal cord stimulator insertion, medication management, psychiatric care, status post lumbar fusion (2010), status post lumbar foraminotomy (2013), status post discectomy (2007) and status post laminectomy (2008). Work status was documented as permanent and stationary. The injured workers pain level was noted as 7/10. Physical examination was notable for lumbar spine with pain upon palpation to the lumbar facets in the L3-S1 region as well as over the lumbar intervertebral spaces, pain noted with lumbar extension and anterior flexion. The plan of care was for Dilaudid 4 milligrams quantity of 150, Flexeril 10 milligrams quantity of 60, Ondansetron 8 milligrams quantity of 30, Oxycontin 40 milligrams quantity of 90, Prilosec 20 milligrams quantity of 30, Tramadol ER 200 milligrams quantity of 30 and Catapres 1.1 milligrams quantity of 90.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Dilaudid 4mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 63-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioid analgesics for moderate to severe pain, such as Dilaudid, may be added. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. The injured worker has a history of low back pain with radiation to the left lower extremity. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." There is no documentation of significant pain relief or increased function from the opioids used to date. Additionally, a pain contract was not included in the provided documentation. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine (Flexeril) Page(s): 63-64, 41-42.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the injured worker has a history of low back pain with radiation to the left lower extremity. The CA MTUS recommends, "muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patient with chronic low back pain...Efficacy appears to diminish over time, and

prolonged use of some medication in this class may lead to dependence." Provider documentation, dated 4/29/15, shows an initial prescription for Flexeril 10 milligrams quantity of 60 tablets. The available records do not show a clearly documented benefit or any functional improvement from prior Flexeril use. There is no clinical indication presented for the chronic or indefinite use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant has not been established. The requested treatment is not medically necessary.

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ondansetron, Antiemetics.

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. This injured worker has a history of low back pain with radiation to the left lower extremity. Provider documentation dated 4/1/15 notes a prescription for Ondansetron 8 mg. There was no rationale provided for the use of this medication. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Oxycontin 40mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin, Opioids Page(s): 97, 76-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to severe pain may be added. Oxycodone (Oxycontin) is a long-acting opioid analgesic. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and

dependency on continued medical care. There is no documentation of significant pain relief or increased function from the opioids used to date. Additionally, a pain contract was not included in the provided documentation. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Proton pump inhibitor.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is no documentation indicating that this patient has had any GI symptoms or risk factors. Based on the available information provided for review, the patient has not been maintained on NSAIDs. The medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Tramadol ER 200mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram). Decision based on Non-MTUS Citation Tramadol (Ultram)Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, the treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Medical necessity of the requested medication has not been established.

Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Cataprine 1.1mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Diabetes Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine Page(s): 34, 35.

Decision rationale: The request is for Catapres 1.1 milligrams, quantity of 90. The injured worker has a history of low back pain with radiation to the left lower extremity. The CA MTUS recommends Catapres after a short-term trial indicate pain relief in patient who are refractory to opioid monotherapy or opioids with local anesthetic for treatment of neuropathic pain. Provider documentation did not indicate the injured worker had efficacy of the requested medication. The injured workers pain was noted to be without change. In the progress note dated 5/26/15 the provider documented the "medication only partially help. Narcotics do not relieve the pain entirely." As such, the request for Catapres is not medically necessary.